DSS

Strong Families – South Dakota's Foundation and Our Future

South Dakota Department of Social Services

Division of Medical Services

Audit Strategy

EHR Incentive Payment Program

July 25, 2012

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THE AUDIT STRATEGY

The audit plan describes the strategy to ensure accurate payments, the process for combating fraud and abuse by verifying criteria related to EHR Incentive Payment Program, as well as a description of the process and methodology to address Federal laws and regulations designed to prevent fraud, waste, and abuse.

1. Overview

South Dakota intends to leverage the existing audit strategies in place for fraud and abuse detection and ensure accurate payments for the electronic health records (EHR) incentive payment program. Suspected fraud or abuse involving EHR incentive payments can be reported through existing means such as the Surveillance and Utilization Review Subsystem (SURS) and Medicaid Fraud Control Unit's (MFCU) fraud hotline and fraud email account.

To prevent improper payments, fraud, waste and abuse, the EHR Incentive Payment Program will work with the SURS unit or DSS Provider Reimbursements and Audits staff, dependant on staff availability.

The SURS unit within Division of Medical Services (DMS) has a Payment Control Officer and four investigators. The SURS unit is tasked with safeguarding against unnecessary or inappropriate use of DMS services or excess payments; assesses the quality of those services; and conducts post-payment reviews to monitor the use of health services.

DSS Provider Reimbursement and Audits has 4 internal auditors. The responsibilities of Provider Reimbursements and Audits are to establish reimbursement methodology and reimbursement rates. They also provide auditing services for programs within the Department of Social Services for the verification of the provider's program costs and for compliance the established reimbursement requirements of the applicable program.

DMS will seek requests for proposal to secure a contractor to conduct meaningful use audits on Medicaid providers. CMS, and its contractors, will perform audits on Medicare and dually-eligible providers.

2. Guiding Principles

The Division of Medical Services (DMS) audit strategy will be based on the following general guiding principles:

- Any eligible professional or eligible hospital attesting through the SD Medicaid EHR Incentive Payment Program will undergo pre-payment verification and may be subject to a post-payment audit.
- The audit strategy will be flexible to accommodate Adopt, Implement, Upgrade (AIU), and Meaningful Use (MU) stages 1, 2, and 3.
- DMS will apply several methods to reduce provider burden while maintaining integrity of the oversight process. Through the statewide HITECH multi-collaborative, DMS expects to have a broader reach to providers. DMS collaborates with HealthPOINT to communicate and share accurate information regarding the EHR Incentive Payment Program with providers. In addition, DMS intends to send a clear and consistent message to providers through its communication strategy and the resources for providers to use in the program. DMS expects communication with providers will improve their understanding of the program, which in turn should decrease abuse and non-compliance. DMS will also use claims data, immunization

registry and electronic lab reporting, the SD Health Link/planned HIE, and external data sources for verification reducing provider burden.

3. Methodology

DMS will utilize existing oversight activities and integrate processes related to the incentive program into audits and reviews already in place. The DMS EHR Incentive Payment Program's audit strategy is composed of two main components:

1. DMS will avoid making improper payments by ensuring that all payments are made according to EHR incentive funding requirements to Eligible Professionals (EPs) and Eligible Hospitals (EHs) through a combination of monitoring and validation prior to payment. This includes SD Medicaid EHR incentive attestation portal system edits and manual review of red flags/high risk elements.
2. DMS will ensure proper payments through selective and targeted audits after payments are disbursed. The post payment audits will consist of primary and secondary data source validation, of targeted and random sampling of EH and EP paid providers..

DMS will rely heavily on pre-payment verifications to ensure proper payment. EHR incentive program staff performs pre-payment verifications. The audit pool for post-payment audit will be composed of flagged providers during pre-payment checks and areas where system edits lack. Risk based elements will be identified to assess which eligibility, AIU, and MU measures are likely to be subject to incorrect information. Then a three-tiered approach will be used for post-payment audit to validate submitted attestations. The three-tiered approach will be composed of primary, secondary, alternate data analysis.

3.1 Risk Assessment Approach

Risk profiles will be established to efficiently identify potential audit targets and to assess which eligibility, AIU, and MU measures are likely to be subject to incorrect information. A combination of primary and secondary, and alternate data validation approaches will be applied.

The risk of waste, fraud, and abuse is low when provider's attestations can be verified using data sources such as claims data, cost reports, and other reports. A medium risk level involves attestations submitted by provider that are not easily verified. A high risk for improper payment, waste, fraud, or abuse occurs for provider attestations where reports or benchmarks to verify attestations are unavailable or difficult. Examples of high risk elements include encounters or discharges in the denominator for total patient volumes excluding Medicaid patients. Lack of providing documentation during attestation would raise the risk profile for audit.

Summary of Risk Profiles by Providers

EP

- Low risk EPs
    - Individual encounters with no out of state encounters. EPs with reported encounters equal to or less than5% of MMIS claims data are considered low risk. A random sample of 5% of EPs in this category will be referred for post-payment audit.
    - At least one public health measure met through secondary (DOH) data validation.
    - All MU denominator and numerator inter criteria comparison met.
    - All exclusion documentation/explanation provided.
- Medium risk EPs
    - Group encounters, individuals at multiple locations.
    - EPs with reported encounters within 6-15% of MMIS claims data are considered medium risk.
    - Global billing specialties such as obstetrician or gynecology specialty with a global billing in the provider paid Medicaid encounter. A random sample of 10%of EPs in this category will be referred for post-payment audit.
    - Documentation lacking and explanation for MU exclusion partially provided.
    - All providers not reported as testing/meeting at least one of the MU public health measures by SD DOH.
- High risk EPs
    - EPs not traditionally enrolled individually in the MMIS in order to capture claims history at the individual level. Individuals in Federal Qualified Health Center /Rural Health Center (FQHC/RHC) employed EPs attesting individually and not at a group level, individuals with large number of out of state encounters to meet the minimum patient volume threshold, individual with needs inclusion, and all EPs not categorized above are considered as high risk. Additionally, EPs with reported encounters of more than 15% of MMIS claims data are considered as high risk. All EPs in this category will be referred for post-payment audit.
    - EPs that have been selected for other Medicaid audits.

EH

- Low risk
    - Medicaid patient encounter (inpatient discharges and emergency department encounters) reported by EH are equal to or less than 5% of MMIS Claims data except for Children's hospital are considered low risk.

  - Children's hospital that use cost reports with a four year continuous (consecutive 12 month) cost reporting period.
  - A random sample of 5% of hospitals in this category will be referred for post-payment audit.
- Medium risk
  - Medicaid patient encounter reported by EH within 6-15% of MMIS Claims data.
  - Charity care charges or uncompensated care charges not supported by cost reports.
  - A random sample of 10% of hospitals in this category will be referred for post-payment audit.
- High risk
  - EHs include out of state Medicaid encounters when reporting patient volume.
  - EHs with large variance of Medicaid encounters when compared to MMIS claims data.
  - EHs using less than four years of data from cost reports to calculate the average growth rate portion of the incentive payment.
  - EHs using more than 5% variance in Medicaid inpatient days and discharges used to calculate the incentive payment.
  - Medicaid patient encounter reported by EH for more than15% of MMIS Claims data.
  - All EHs in this category will be referred for post-payment audit.
  - EHs that have been selected for other Medicaid audits.

Meaningful Use Core and Menu measure audit will primarily target measures with high control risk where verification data is available as described in section 4.2.

Risk levels associated with each element for EP and EH attestations are detailed in subsequent sections.

Risk profiles will be further expanded on during the first year. The first year will involve a significantly higher number of statistically valid providers to be profiled. Based on first year findings, DMS will further create risk/exception reports for providers that fall outside of established criteria. DMS anticipates risk assessment review on an annual basis upon post- payment reviews and trend assessments and will update the audit plan accordingly.

3.2 Three Tiered Approach

3.2.1 Tier 1: Primary Data Validation

DMS will leverage existing resources currently available including data in the MMIS, provider enrollment subsystem, extracted claims data, and hospital cost report data for disproportionate share hospital (DSH) reports for primary data validation. DMS will use reports from the attestation portal to perform statistical analysis for outlier anomaly detection and benchmarking.

Inter-criteria comparison will be used to examine inconsistency in attestation responses as several meaningful use measures use the same denominators. Also, consistency in the reported patient encounters, EHR certification numbers, documentation and other requirements among EPs using group patient volume will be reviewed.

3.2.2 Tier 2: Secondary Data Validation

Review of provider submitted documentations such as practice management system reports, billing reports, financial and accounting data, CMS level data (Research & Support User Interface and Microstrategy Business Intelligence reports data) and additional auditable data will be performed. Medicare and Medicaid cost reports, DOH Electronic Lab Reporting (ELR) and immunization registry (IR) will be consulted.

3.2.3 Tier 3: Alternate Selection Approach

The alternate method targets providers that were not flagged during tier 1 and tier 2 validations. Targeted audits made on a selective basis as well as post-payment review of the random audits will be completed. Criteria for targeted audits include:

- Providers with largest hospital incentive payments
- A provider that has reported invalid information or submitting insufficient credible information to support attestation. For example, this includes not submitting/uploading appropriate AIU/MU documentation
- A provider that has become subject of unrelated program integrity review
- A provider that selects to inactivate their status as Medicaid provider or is terminated from the Medicaid program
- Or by a referral
- An EPs practices predominantly in an FQHC or RHC and claims needy individual patient volume
- An EP working at multiple FQHC/RHC locations must meet the 50% of total encounters over a period of 6 months in the most recent calendar year. DMS will work with HealthPOINT and/or the provider to verify multiple payer's data. This is considered a low risk element and more likely to be audited only if other concerns were raised during post payment.
- EPs in large practice groups of 15 or more providers with 100% of the EPs attesting for EHR Incentive payments.

4. Pre-Payment Verification Methods, Audit Elements and Sources

Staff of the EHR Incentive Payment Program will be responsible for prepayment audits. DMS will use primary and secondary data sources for audit. As part of the attestation process, providers indicate whether they are working with a regional extension center such as HealthPOINT. If the provider is using the services of HealthPOINT, DMS will coordinate with HealthPOINT to validate whether the provider is using a certified EHR, or whether the provider has achieved meaningful use. DMS will work with providers and HealthPOINT to assist EPs and EHs to meet the requirements of AIU/MU prior to applying for incentive payment.

DMS will verify attestation information submitted by providers and will perform high level checks. DMS intends on expanding further automation of auditing checks built into its incentive attestation portal as it is in the process of updating its legacy MMIS. During this transition period, some manual verification will be utilized. Upon replacement of the legacy MMIS, DMS plans on furthering automated audit checks. Below is a detailed narrative on selected audit elements

4.1 Eligibility

4.1.1 Enrollment

The provider must be enrolled with Medicaid in DMS. This will be verified through a system check in MMIS/SD MEDX. Verification will be made through the National Level Repository (NLR) and MMIS including provider name, NPI, business address, phone, the tax identification number (TIN) to which provider would like payments made, CMS Certification Number (CCN), the state from which providers are applying to receive incentive payments, and group affiliations. DMS maintains a list of hospitals and CCNs. If a provider is not actively enrolled provider, the system edits in MMIS are in place to prevent non-enrolled providers from payment. This is a low risk element.

4.1.2 Licensed, Non-sanctioned/Excluded

The provider must not be sanctioned and is properly licensed. There are existing auditing strategies in place to ensure that providers are enrolling and actively participating in the DMS program, billing and receiving payment in MMIS/SD MEDX system and are licensed and not sanctioned. An active provider is one who is active in MMIS and approved to bill for services. Active Medicaid providers are providers who are not currently under sanctions and are duly licensed within the state. DMS provider enrollment process encompasses these checks prior to enrollment. During the pre-payment audit, the provider enrollment checks will be repeated including checks in MMIS, provider enrollment files, office of the Inspector General exclusion list/List of Excluded Individuals/Entities, program integrity files, and state licensing boards. An exception for licensure is for IHS providers as they are not required to be licensed in the State in which they practice for IHS. IHS providers are exempt from having to hold a SD License pursuant to South Dakota Codified Law (SDCL 36-2-8.). DMS may consider the use of IHS practice management, meaningful use and other systems for verification of requirements for IHS providers. This is a low risk element.

4.1.3 Non-hospital based

DMS will verify whether or not an EP is hospital based by analyzing a EPs Medicaid claims data sources from the preceding calendar year. If the EP is hospital based, then the EP would provide 90% or more of their services in an inpatient or emergency room setting (Place of Service codes of 21 and 23). This verification is performed by a manual query of

the claims database per EP except when the provider is practicing predominantly in an FQHC/RHC setting. This is a low risk element.

4.1.4 Physician Assistant (PA)-led FQHC/RHC

1. The PA is the primary provider in the FQHC or RHC
2. The PA is a clinical or medical director at a FQHC/RHC clinical site of practice
3. The PA is an owner of an RHC

If an FQHC or RHC has multiple sites and one of them is led by a PA, then PAs in all sites are eligible for the program.

Prepayment verification of "primary provider" verification will take into account when compared to other providers in the clinic, the PA:

1. PA assigned the most patients in the clinic
2. PA with the most patient encounters
3. PA with the most practice hours
4. More Full time PAs than more full time physicians
5. Single provider

The clinical or medical director at a FQHC/RHC clinical site of practice and ownership or RHC roles for PAs can be validated with documentation including public documents and internal data provided on the Provider Enrollment subsystem. If needed, DMS will be requesting dated documentation from FQHCs and RHCs from which one or more PAs apply including position descriptions, emails, meeting minutes and other organizational documents that yield conclusive indications of clinical leadership. RHC ownership documentation, the physician or PA collaborative agreement, review of the clinic practice management system for patient loads or clinic organizational documents supporting clinical director role, and Uniform Data Systems (UDS) reports may be requested if PA led criteria is unclear. DMS maintains a pre-determined list of FQHC/RHC clinics. Furthermore, FQHC/RHCs work closely with HealthPOINT to attest for incentives. This is considered as a low risk element due to a low number of PA led FQHCs/RHCs.

4.1.5 Participate in Medicare and Medicaid

If an EH participates in both Medicaid and Medicare, then audit checks at the CMS Registration and Attestation System National Level Repository (NLR) level will be adopted except for verification of the eligibility, the 10% minimum Medicaid patient volume, and other state level requirement checks done by DMS. If provider is an EP, they may switch programs once before 2014. EHs deemed meaningful user under the Medicare EHR Incentive Payment Program will be a meaningful user under the DMS program if other eligibility requirements are met. NLR level reports will be used to verify participation information for providers including if an EP switched between Medicare and Medicaid programs more than once.

4.1.6 Patient Volume Calculation Method (Medicaid and individuals with needs patient volume)

DMS will continue to closely work with providers and HealthPOINT to ensure accurate numerators, denominators and calculations demonstrate patient volume that is as flexible and as inclusive as possible while balancing the administrative burden. The attestation portal captures the EP patient encounters information (including those practicing in an

FQHC/RHC) and calculates the minimum 90-day patient volume of 30% and pediatrician's demonstration of 20% patient volume in a calendar year. Upon capturing the relevant information from EHs, the attestation portal calculates the Medicaid patient volume to determine the minimum 10% Medicaid patient volume except for Children's hospital.

- When the provider enters the start date for demonstrating patient volume, the incentive attestation portal calculates the end date of the 90 day period.
- The provider is prompted to enter patient volume in any continuous and representative 90 day period the previous year. DMS has system edits in place for patient volume reported in previous year based on program participation year. Initially, a manual check was performed to ensure that patient volume was reported in the previous year.
- For eligible professionals, if the provider is attesting as a group, then the group Medicaid patient encounters is checked for reasonableness through queries on the claims database. Staff verifies that EPs within their group practice report encounters that are consistent. Also staff will look for any indications if an EP that belongs to a group attested individually. Staff will outreach to maximize EP participation since this will affect other EPs attestations in the same group.
- Calculations of patient volumes also are automated in the portal. When the provider enters the numerator and denominator, the portal calculates the patient volume percentage to determine eligibility. Providers not meeting the minimum patient volume thresholds would not be able to submit attestation. The EHR incentive program staff uses claims database to validate the Medicaid encounter (numerator). If there is a significant difference with the submitted numerator and claims validation (>15% difference), the eligible professionals and hospitals will be requested to submit auditable documentation. This will be a high risk element.

Numerator and denominator calculations can be further verified if the providers already have existing EHRs with a review of EHRs or practice management information. Otherwise, DMS will work with the provider to determine acceptable proof. These may include copies of schedules, claims to different payers, billing records and other auditable proofs. For individuals with needs patient volume calculations, DMS will depend on the records of the FQHCs and RHCs and copies of billing records. Other documentation may be required. DMS will work with these facilities individually to ensure that all patients on Medicaid, CHIP or adjusted fees according to income are counted in the numerator. As FQHCs/RHCs submit Medicaid/CHIP claims, encounter data, and clinic data to Health Resources & Services Administration (HRSA,) DMS may also verify individuals with needs volume through claims by source of payment submitted to HRSA.

DMS collaborates with other state Medicaid agencies to verify out of state Medicaid encounters if a provider included encounters from Border STates to meet the minimum patient volume threshold

4.1.7 Average Length of Stay (LOS)

To verify that Acute Care hospitals meet the average LOS requirement of 25 days or fewer in the fiscal year prior to the payment year, Medicaid/Medicare cost reports, MMIS claims data, utilization and hospital records will be consulted. Providers may be required to submit auditable data source such as financial reports, accounting records and cost reports if

necessary. Based on the provider self attestation, the portal calculates Average LOS and system edits are in place. This is a low risk element.

	Eligibility Prepayment Verification	
Risk Category	**Electronic/Manual Sources**	**Risk Level**
Provider must be of an eligible type (EP/EH type)	Automated checks in portal; MMIS, provider files	Low
Provider must be enrolled in DMS	MMIS, SD MEDX, provider enrollment files	Low
Provider must not be sanctioned and is properly licensed/not excluded.	MMIS, provider enrollment files, office of the Inspector General exclusion list/List of Excluded Individuals/ Entities, program integrity files, state licensing/ accreditation boards, associations, NLR Research and support user interface (R&S UI)	Low
Provider must not be hospital based unless practicing in FQHC/RHC	MMIS claims data	Low
For individual with needs patient volume, EP practices in FQHC/RHC	MMIS claims data show Medicaid and CHIP, provider enrollment records, practice management system records, and other auditable resources.	High
PAs at FQHC/RHCs that are "so led" by PA	RHC ownership documentation in SD MEDX, the physician or PA collaborative agreement, review of the clinic practice management system for patient loads or clinic organizational documents supporting clinical director role.	Low
Eligible professional participates in both Medicaid and Medicare	NLR R&S UI and micro-strategy reports	Low
Patient volume is reported in the previous year	Manual check based on attestation detail, program year, payment year, and date of attestation	Medium
Patient volume is reported for 90 continuous days	Automated 90 day calculation in portal	Low
Patient Volume calculation: 30% for EPs using Medicaid volume and individuals with needs; 20% for pediatricians; 10% for Acute care and Critical Access Hospitals	MMIS Medicaid/CHIP claims data , HealthPOINT, auditable payer data , practice management reports, HRSA reports and Medicaid encounters, All payer data may be requested/required to check denominator,	High
Average Length of Stay (LOS) 25 days or fewer for Acute Care hospitals	Cost reports, financial/accounting statements, and MMIS data.	Low
No EP or EH begins receiving payments after 2016 and payments end by 2021	Automated participation years check in portal, MMIS, NLR R&S UI, and micro-strategy reports	Low

4.2 Meaningful Use

As DMS plans to accept stage 1 meaningful use attestations from providers beginning in the fall of 2012, a review of meaningful use attestations will be performed within 90 days of issuing a meaningful use incentive payment. Any EH deemed a meaningful user under the Medicare EHR Incentive Program will be a meaningful user under the DMS Medicaid EHR incentive program if other eligibility requirements are met. Prior to issuing payment, staff will perform Medicaid eligibility requirement reviews based on information provided in the attestation portal. Audit of dual Medicare and Medicaid EHs for meaningful use measures will be done by CMS. DMS plans to audit all Medicaid requirements of EHs except for meaningful use measures. DMS will work with HealthPOINT, DOH and providers to verify the reported Core, Menu and Clinical Quality Measures.

Numerous system edit checks are built into the SD Medicaid EHR Incentive Payment portal for meaningful use. Calculation of thresholds for meeting core and menu measures is automated in the attestation portal. Providers must attest to and be able to demonstrate core, selected menu, and clinical quality measures and provide verifiable documentation. Juxtaposing numerator /denominator and yes/no measures including in the portal prompts the provider to include explanations for certain measures to aid with audit. The attestation portal enables the provider to enter explanations for exclusions, detail eRx service and pharmacy, name CDS rule, specify with whom test for clinical information exchange was done, and name a condition for patient list. These are used to mainly support post-payment audit but may also be used during pre-payment.

The attestation portal allows the uploading of supporting documentation and explanations. Providers who have not submitted supporting documentation such as CQM measures from direct output of EHRs may have elevated risk level for audit. Validation of CQMs completeness is automated in the portal. Once providers begin submitting meaningful use core, menu and clinical quality measures, DMS staff will conduct the following high-level checks:

- Confirm that clinical quality measures have been submitted to DMS. Validation of CQMs completeness is automated in the portal. For 2012, completeness of CQMs will be checked. DMS will review a detailed validation/audit of CQMs for stage 2 meaningful use and beyond.
- Validation of Yes/no and Numerator /Denominator calculations for meeting thresholds is automated in the attestation portal.
- A review of the aggregate or statistical reports generated by the EHR confirming the measures of meaningful use (core and selected menu measures) of those indicated via attestation will be matched. Practice management documents may be consulted. If a standard report is not available, staff will work with the provider to determine an acceptable process for verification if requested. This will be data mainly reviewed during post-payment audit
- Review documentation confirming the exchange or testing of electronic health records. Once operational, the HIE will be a source of verification.
- If a provider is working with HealthPOINT, DMS will collaborate with HealthPOINT to explore meaningful use data sources

Meaningful Use Pre-payment Verification		
Risk Category	**Low risk**	**Risk Level**
MU EHR reporting period, 90 days in first year, 1 year in subsequent years	Automated calculation of 90 days and 1 year,	Low
Year of participation	Automated in portal, manual check with NLR RNS UI, Microstrategy and BI reports	Low
50% of all encounter take place in locations with certified EHR	Manual review of MMIS, provider documentation, attestation portal, and CHPL	Medium
MU D/N calculations	Automated in portal and validated for meeting thresholds	Low
MU Y/N	Automated check for completeness	Low
MU exclusions- provider enters reason for exclusion on attestation portal	Manual reasonableness check per uploaded evidence or explanations	Medium
MU core requirements are attested and accurate-reasonableness check for measures with similar denominators	Manual check for measures with similar denominators, reasonableness of exclusions explanations or documentation upload, and public health measure verification, EHR repots, HIE, and HealthPOINT data.	See section below
MU Menu requirements are attested and accurate/reasonableness check for measures with similar denominators	Manual check for measures with similar denominators, reasonableness of exclusions explanations or documentation upload, and public health measure verification/DOH, HIE/HealthPOINT, EHR and practice management data	See section below
Clinical Quality Measures are attested, complete, and verifiable	Automated check for completeness in the attestation portal, HIE/HealthPOINT, EHR and practice management data	Low risk in first year

4.2.1 Public health measures

Public health data submission validation: Public health exchange will be a source for verification of data submissions to immunization registry and/or public health electronic lab reporting. ELR. Menu measures related to public health reporting will be checked with the SD public health exchange (IR/ELR) that is currently being implemented. Syndromic surveillance sources from DOH will be consulted. DMS collaborates with DOH and has access to a database with a list of providers that have met the public health measures for stage one of meaningful use. This enables DMS to verify attestations if providers have met at least one or more of the public health measures.

Public Health Measures verification	
Risk Category	**Electronic/Manual Sources**
EP Public Health Measures	
Menu 9: Capability to submit electronic data to immunization registries	Manual; HIE/DOH Immunization registry
Menu 10: Capability to submit electronic syndromic surveillance data to public health agencies	Manual; HIE/ DOH Syndromic surveillance data
EH Public Health Measures	
Menu 8: Immunization registries data submission	Manual; HIE/DOH Immunization registry data
Menu 9: Reportable lab results to public health agencies	Manual; HIE/DOH hub ELR data
Menu 10: Syndromic surveillance data submission	Manual; HIE/DOH hub/ Syndromic surveillance data

4.2.2 Measures with similar denominators

Validation that denominator values are the same for measures requiring "all ED visits method" or "observation services method" have the same numbers in the denominator

EP Measures with same denominators: "measures requiring "unique patient count" during the reporting period should have the same numbers in the denominator

- Core 5: Maintain active medication list - high
- Core 6: Maintain active medication allergy list- high
- Core 7: Record demographics - high
- Menu 5: Patient electronic access - medium
- Menu 6: Patient-specific education sources- medium

EH Measures with same denominators: measures requiring "observation services method" or "all ED visits method" should have the same numbers in the denominator

- Core 3: Maintain problem list- medium
- Core 4: Maintain active medication list- high
- Core 5: Maintain active medication allergy list- high
- Core 6: Record demographics - high
- Menu 5: Patient-specific education sources- medium

4.2.3 Measures with similar numerators and denominators

Certain measures allow the option to limit the population to "only from patient records maintained using certified EHR technology". Relationship between certain numerators and certain denominators is a valid method of validation. For example, if an Eligible Hospital certifies Core measure 3 Maintain Problems List at 80% compliance then it is reasonable to assume that the EH must be at 80% adoption rate for denominator used for measures that allow use of "only from patient records maintained using certified EHR technology". These measures should reflect volumes that are proportionate with the adoption rate.

EH

- Core 1 CPOE for Medication Orders - medium
- Menu 2 Advance Directives - medium
- Core 7 Record Vital Signs - medium
- Core 11 Electronic Copy of Health Information - weak
- Core 12 Electronic Copy of Discharge Instructions - weak
- Menu 3 Incorporate clinical lab test results into EHR as structured data - medium
- Menu 6 Performs Medication Reconciliation - medium
- Menu 7 Send Transition of Care Record - medium

EP

- Core 1 CPOE for Medication Orders- medium
- Core 4 Generate and transmit permissible prescriptions electronically (eRX)- medium
- Core 8 Record Vital Signs- medium
- Core 9 Record Smoking Status- medium
- Core 12 Electronic Copy of Health Information- weak
- Core 13 Clinical Summaries- high
- Menu 4 Patient Reminders- medium

- Menu 5 Patient Electronic Access - medium
- Menu 7 Medication Reconciliation- medium
- Menu 8 Transition of Care Summary- medium

4.2.4 Measures with exclusions

Review of reasonableness for exclusions is based on specialty type, explanations provided in the attestation portal and any uploaded documentation if exclusions are claimed. Lack of submission of documentation may raise the level of risk profile for audit. DMS will explore secondary data sources, benchmarking and other approaches to validate exclusions post-payment.

EP exclusions

- Core 1: Writes fewer than 100 prescriptions during the EHR reporting period of CPOE for medication orders
- Core 4: Writes fewer than 100 prescriptions during the EHR reporting period to report E-prescription rate
- Menu 1: Writes fewer than 100 prescriptions during the EHR reporting period to implement drug formulary checks
- Core 8: Sees no patients >=2 years old or sees measure as having no relevance to practice to record vital signs
- Core 13: No office visits to provide clinical summaries for patients for each office visit
- Menu 4: No patients <=5year old or >=65 year old for Patient Reminders
- Menu 2: Orders no lab tests to incorporate clinical lab test results into EHR as structured data
- Menu 5: Nether orders nor creates information to provide patients with timely electronic access to their health information
- Menu 7: Not a recipient of transitions of care to receive medication reconciliation
- Menu 8: Neither transfers a patient nor refers a patient to another provider for Send Transition of Care Summary
- Menu 10: Does not collect any reportable syndromic information to demonstrate capability to submit electronic syndromic surveillance data to public health agencies
- Core 9: No patients to Record smoking status for patients >= 13 year old
- Core 12: No patient information requests for Electronic copy of health information

EH exclusions

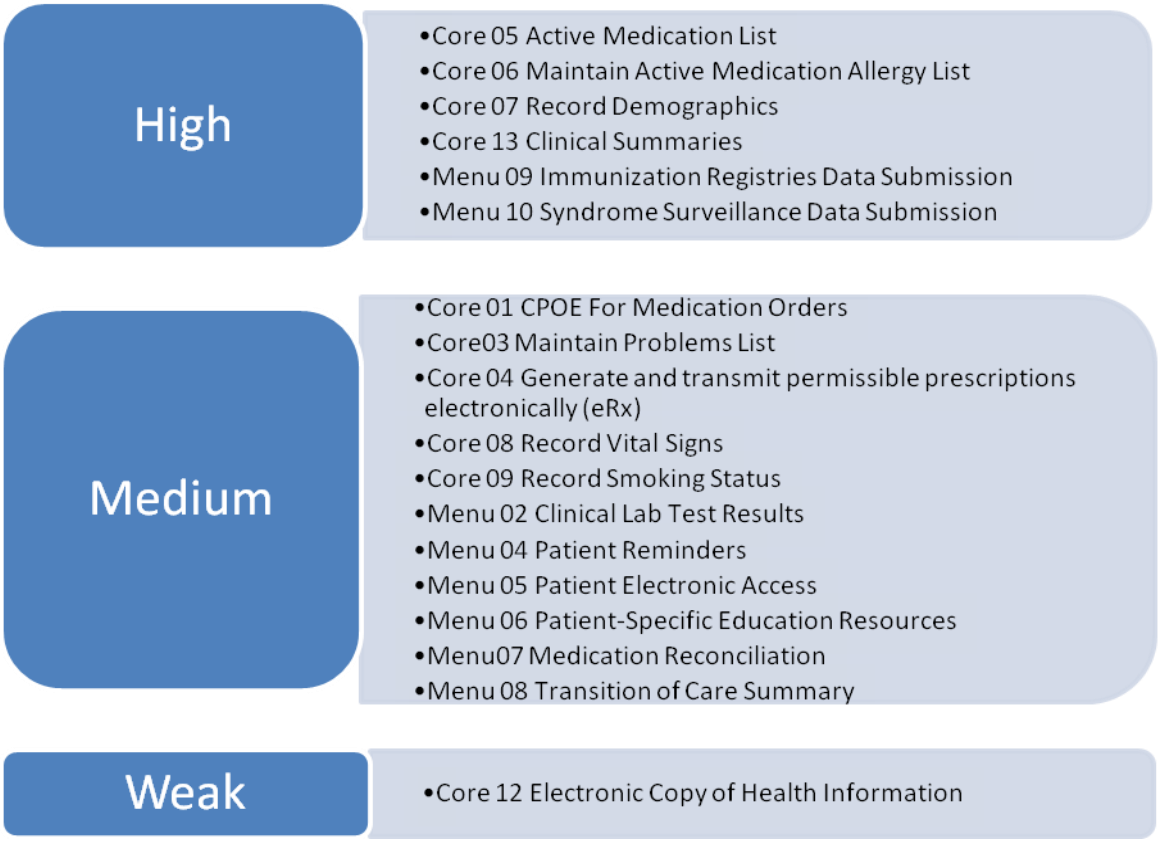
- Core 8: No patients to Record smoking status for patients >= 13 year old
- Core 11: No patient information requests for Electronic copy of health information
- Menu 2: No patients for Advance directives for patients >= 65 years old
- Core 12: No patient information requests for Electronic copy of discharge instructions

Program staff will outreach providers/designated contacts if exceptions exist to the initial prepayment checks. Upon review of the pre-payment checks, program staff will document status on the pre-payment checklist.

4.2.5 MU primary risk level

Post-payment audit of Meaningful Use Core and Menu measures will primarily target measures with high control risk where verification data is available. Some measures are initially excluded from a post-payment review due to lack of information to accurately verify these measures.

EH
Core 02 Drug Interaction Checks
Core 09 Clinical Quality Measures
Core 10 Clinical Decision Support
Core 13 Electronic Exchange of Clinical Information
Core 14 Protect Electronic Health Information
Menu 1 Drug Formulary Check
Menu 4 Patient Lists
EP
Core 2 Drug Interaction Checks
Core 10 Clinical Quality Measures
Core 11 Clinical Decision Support
Core 14 Electronic Exchange of Clinical Information
Core15 Protect Electronic Health Information
Menu 01 Drug Formulary Checks
Menu 3 Patient Lists
Risk levels for EP Menu Measures are listed below. Measures with high risk level are primary targets for EP post-payment audit. All post-payment audit of MU measures for EHs will be done by CMS.



4.3 Retention of documentation

During attestation, EPs and EHs attest to the accuracy of the information submitted and include an agreement on the portal to retain records for a minimum of six years prior to submitting their

attestation. For subsequent years, providers will be required to retain documentation for a minimum of six years from the date of an approved application that resulted in a SD Medicaid EHR incentive payment. Failure of providers to retain documentation for a minimum of six years will result in a review by DMS and may result in adverse action against the EP or EH such as recoupment of incentive payment and other actions.

4.4 Payment Calculations

Payment amount validations are automated for EPs based on year of participation, type of professional, and number of payments. Payment amounts will be checked that EPs meeting 30% patient volume are for $21,250 in the first year and at $8,500 subsequent participation years. Attestation portal rules automatically apply the lower payment amount for Pediatricians meeting at least 20%-29% patient volume at $14,167 the first year and $5,667 subsequent years of participation.

Hospital cost reports and disproportionate share (DSH) surveys, audited financial reports and accounting records will be reviewed for accurate calculation of payment. The portal provides EHs correct lines to include from Medicare cost report worksheets. EHR incentive staff maintains estimated incentive projections and compare and work closely with EHs attestations to ensure accurate calculation of EH incentives. Hospitals with non-continuous cost reporting period will be monitored. The following should be satisfied for accurate payment calculation

- Accurate lines from cost reports are used to calculate total discharges, Medicaid and hospital days, total hospital charges and charity care charges
- Dually eligible hospitals are not including Medicare Part A or Part C acute inpatient days where Medicare was the primary payer
- Charity care charges or other uncompensated care charges are reported accurately
- Exclusion of nursery, observation, rehab and psych days (inclusion of acute inpatient days)

DMS will apply the most accurate information available at time of incentive calculation. DMS accepts up to a 5% variance in calculation of incentive payments for EHs. However, if variation is due to inaccurate data reported such as incorrect years or inclusion of non-acute inpatient bed days, then data would need to be reconciled to reflect correct payment calculation.

Payment Pre-payment Verification		
Risk Category	**Electronic/Manual Sources**	**Risk Level**
Payments for a maximum of six years for EP and maximum of three years for EH.	Automated portal and MMIS Micro-strategy report	Low
No duplicate payments	NLR Micro-strategy reports, RNS UI, and automated in portal/MMIS	Low
Provider reassigning payment	NPI/TIN match in MMIS, both manual and automated	Low
Accurate calculation of EP payments	Automated in portal	Low
Accurate calculation of EH payments as submitted by the provider	Automated in portal, cost reports/auditable data	
Accurate lines and correct years from cost reports are used to calculate total discharges, Medicaid and hospital days, total hospital charges and charity care charges	Automated cost report lines displayed to provider on attestation portal, manual check of Medicare and Medicaid cost report, DSH, financial and accounting reports	Medium

Payment Pre-payment Verification		
Risk Category	**Electronic/Manual Sources**	**Risk Level**
Dually eligible hospitals are not including Medicare Part A or Part C acute inpatient days where Medicare was the primary payer	MMIS claims data, and cost reports	Medium
Charity care charges or other uncompensated care charges are reported accurately	DSH and audited financial reports	Medium
Exclusion of nursery, observation, rehab and psych days (inclusion of acute inpatient days)	Manual check of cost report, MMIS	Low

5. Payment

In order to avoid improper or duplicate payments, the EHR Incentive Payment Program staff will check the National Level Repository, Microstrategy reports and Research and Support User Interface prior to authorizing payments and update the NLR with payments made. To avoid any underpayments or overpayments, incentive payments will be reviewed by both program managers and finance staff. Upon successful duplicate payment check, payment files are generated. Incentive payments to EPs and EHs will be disbursed through MMIS. This will guarantee validity on provider TINs and edits and fund codes have been applied in order to separately track EHR incentive payments. Incentive payments are reported and monitored through the CMS 64 financial report. The number of payments, year of payment, payment amount, and payment dates are automated and tracked in attestation portal and MMIS per provider.

6. Post-payment Verification Methods

Audits may be either desk reviews or field audits. A combination of primary, secondary and alternate approach described in section 3 will be used to validate flagged providers for post-payment audit. This will trigger manual desk reviews of post-payment audit. SURS or Provider Reimbursements and Audit will audit data in the attestation portal and documents received from EP or EH for AIU payments. The Division of Medical Services will contract with an outside entity to conduct MU audits of EPs. If more information is required to complete the desk audit, the appropriate audit staff will outreach the contact person listed in the portal. Acceptable forms of documentation requested from providers include support for total patient encounters, discharges, acute Medicaid days, charity care charges for which encounter variance is greater than 5%. Standard EHR reports supporting meaningful use adherence (such as exclusion documentation, EHR reports, etc), EHR certification documentations, and other supporting documentations may also requested. The previous sections details forms of documentations that may be requested. The attestation portal will provide a way for EPs or EHs to upload requested records via the portal when possible. In addition, data sources to be used include MMIS claims and encounter data, utilization data, auditable financial and accounting reports, cost reports, NLR Microstrategy business intelligence reports, Research and Support user interface, Certified HIT Product List and any opportunities to collaborate with associations.

If a desk review is not satisfactory, then a field audit will be conducted. The field audit is subject to available resources. If a field audit is required, a formal audit letter will be sent to the provider, and the letter will include a request to schedule the field audit. During the field audit, staff will review and witness source of documentation, workflow, demonstration of system, and other relevant material. The prior section outlines additional details on the electronic sources to be used. CMS will audit meaningful use of EHs. An outside contractor with the Division of Medical Services will conduct the meaningful use audits of EPs.

SURS or Provider Reimbursements and Audit will perform random audits of post-payments for further in-depth review of first year AIU payments. DMS is planning to request proposals to secure a contractor that will conduct random audits on Medicaid providers for meaningful use. The random audit of AIU payments is inclusive of every EP and EH so that every provider has a chance of being picked for review. The number of random sampling performed will be based upon the total number of EPs and EHs who received AIU incentive payments. As described in section 3 risk assessment Random sampling of providers during the attestation tail period will be weighted to ensure every provider gets an equal chance of selection. Meaningful use measures that are verifiable (high control risk) and high probability for errors will be the primary targets for audit. Appendix D illustrates elements of post-payment audit which includes:

- Provider practices predominantly in a FQHC/RHC clinical location for over 50% of total encounters over a period of 6 months in the most recent calendar year.
- Check denominator for provider's patient volume.
- At least 80% of patients must have data in the certified EHR.
- Meaningful use measures: High risk EP core and menu measures are primary targets of post-payment audit.

The sources SURS or Provider Reimbursements and Audit can utilize to verify data include EHR reports, HIE, HealthPOINT, DOH, Practice management reports, Surescripts and other auditable data sources.

If an audit identifies overpayments, underpayments, or improper payments, the amount determined as an overpayment or improper payment will be recouped from the provider in accordance with existing procedures. Improper incentive payments are those made to an ineligible hospital or professional. MMIS will total overpayments identified at which point the provider is contacted in writing. Repayment is recovered by check and due within 30 days of notification. EHR incentive funds recouped from providers will be identified on the CMS 64 in accordance with EHR Incentive Payment Program specifics as well as regular reporting procedures.

If abuse is detected, staff will develop a report by eligible provider type. A notice to the provider is sent to recoup payment. If abuse occurred due to the provider misunderstanding, then EHR Incentive Payment Program staff and SURS unit or Provider Reimbursements and Audit will follow up with providers with requests to repay, educate and recover the incentive payment. Providers have 30 days to appeal in writing even though DMS may adjust the overpayment amount after this date, based on additional documentation or provider correspondence.

If fraud is detected, the Division of Medical Services will refer it to the Medicaid Fraud Control Unit (MFCU) of the State Attorney Generals Office for further action, in accordance with existing DMS policies and the Memorandum of Understanding with the MFCU. MFCU will complete an independent review of possible provider fraud in the EHR Incentive Program. Upon determination of by MFCU that there is a credible allegation of fraud, MFCU will request that DMS suspend all Medicaid payments to the provider and place the provider on pre-payment review. DMS will send a notice to the provider of its suspension of program payments within five days of taking such action without disclosing specific information concerning ongoing investigation.

DMS currently has plans to conduct an internal audit of agency management controls over the incentive payment eligibility determination and disbursement processes. The internal audit process will begin within 15 months of the first EHR incentive payments.

7. Documentation

DMS staff uses an AIU audit pre-payment checklist during the pre-payment verification. Appendix A and B respectively illustrate the EP Pre-payment verification worksheet and the EH pre-payment verification worksheet.

Appendix C illustrates a sample spreadsheet of audit pools and summary findings that will be used for AIU post-payment review. A summary report will be maintained and shared.

The contractor secured to conduct meaningful use audits on Medicaid providers will include an audit manager. The audit manager will provide the state with documentation and audit findings.

8. Timeline

Since the launch of the incentive program in December 2011, DMS has been performing pre-payment verifications of attestations submitted by providers. Post-payment audits for AIU payments are scheduled to start in the 4th quarter of FFY2012. DMS plans to begin accepting meaningful use attestations in fall 2012. Post-payment audits for meaningful use attestations are planned for first quarter of FFY 2013 within 60-90 days of issuing the first meaningful use incentive payment. Post-payment audit of meaningful use will be conducted on a quarterly basis.

9. Evaluation and Reporting

Audit findings will be reviewed, analyzed and presented throughout the process and upon the quarterly audit completion. Findings will be assessed if there is a need to revise audit process and pools such as increasing or decreasing audit pools, addition of new audit elements and other categories. Findings will be used to identify areas of improvement and enhancement of provider educational materials. Audit procedures and documentation will be periodically updated.

SURS or Provider Reimbursements and Audit will report audit results and appeals through the CMS HITECH Research and Support User Interface.

10. Auditing Steps

1. Profiling activities- Perform pre-payment audits upon provider attestation and identify providers to be profiled/audited through flagged, targeted as well as a random statistically valid sampling of incentive payments to providers.

2. Request records for post-payment review and perform complete check of records submission. DMS will work with the provider to identify acceptable forms of proof. If additional documentation is requested as a result of an audit, the provider will submit the requested documents to DMS.

3. Perform a desk review audit review includes verification of items on the attestation form and record request.

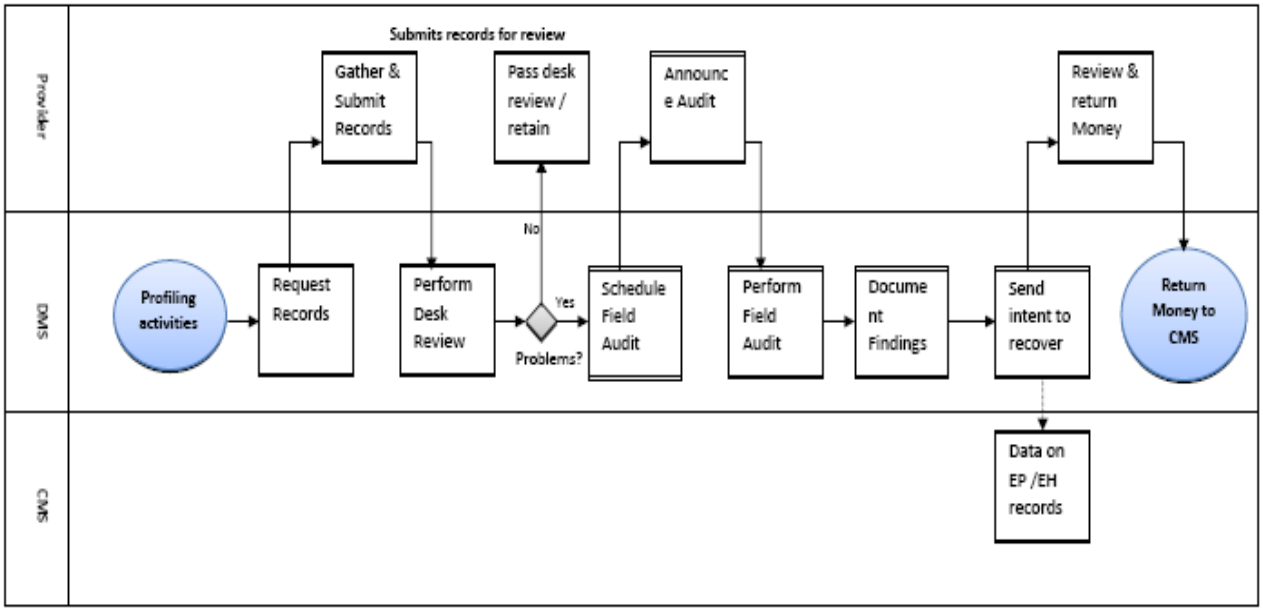
4. If the audit reveals the incentive payment was appropriate, document findings. If the desk review was not satisfactory, send a request to schedule a field audit.

5. Perform field audit.

6. Document audit and findings report and communicate.

7. Request notice of intent to recover in writing. Notify finance of amount and discovery date.

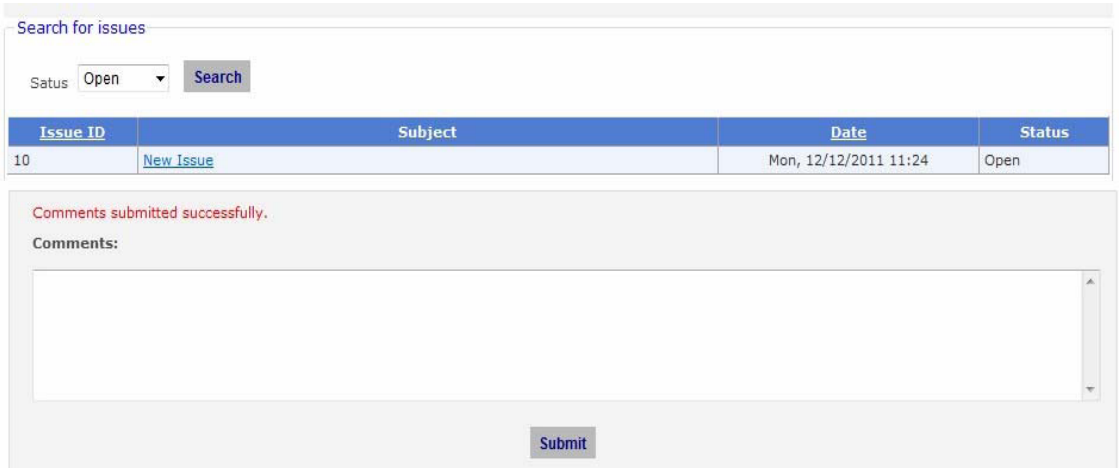
8. Upon receipt of recovery amount, notify Division of Finance who will return FFP to CMS.


Provider
DMS
CMS
Submits records for review
Gather & Submit Records
Pass desk review / retain
Announc e Audit
Review & return Money
Profiling activities
Request Records
Perform Desk Review
No
Yes
Problems?
Schedule Field Audit
Perform Field Audit
Docume nt Findings
Send intent to recover
Return Money to CMS
Data on EP /EH records

11. Provider Appeals

The existing provider appeals process will allow providers to appeal the results of the audit determinations of the EHR incentive payment The first recourse is to submit a request to the program manager.

DMS has built an informal process in the attestation portal for providers as an initial step to issue resolution. Eligible professionals and hospitals may respond to a DMS determination through an online issue resolution mechanism on the attestation portal. Provider can open an issue, submit and view the status of an issue.



Providers also have an opportunity to submit/upload information such as required documentation and track status. When a provider enters an issue on the EHR incentive portal, a notification is sent to the EHR incentive program staff who will work with the provider to resolve issues on a timely manner. For payments denied/pending status, staff will work with provider for issue resolution by requesting additional information or encouraging provider to correct and re-attest. If no resolution, then notification of the determination (including the basis for the decision) and information on a formal appeals process will be provided. Staff will work with the provider to resolve the issue prior to a formal appeals process.

If the provider is not satisfied with the final determination of DMS, then the provider has the right to an appeals hearing to the Office of Administrative Hearings (OAH), an independent division, within 30 days of the notice of action. The Administrative Rules of South Dakota and the South

Dakota Codified Law SDCL 28-6-6 and chapter 67:17:02.1-26 governs appeals practice and procedures before state administrative agencies.

A provider can file a notice of appeal:

- By writing a letter of explanation
- Request must state the reasons as to why the provider thinks the action is inaccurate and include any additional information, data, or documentation that supports the appeal. The requesters address with zip code and telephone number should also be included
- Be received by the agency and at the address indicated in the notice of action within 30 days of the date of the notice of action (date of notification letter)

Appendix A. Eligible Professional Pre-payment Verification Worksheet

Provider Name: **Contact:**
Provider #: **NPI:**
Program Qualification Year: **Payment Year:**
Status:

	Procedure	Date and Note
	REGISTRATION INFORMATION	
☐	Check if provider is enrolled in MMIS/SD Medx. If not enrolled, contact provider to direct them on how to become a South Dakota Medicaid provider. Refer to check for active status through their practice's contact such as the billing staff in your practice and to become a Medicaid provider with the South Dakota Division of Medical Services at 1-866-718-0084 or https://dss.sd.gov/sdmedx/includes/providers/becomeprovider/index.aspx ___not enrolled ___enrolled as a billing provider ___enrolled as servicing provider: ___assigning payment to self ____assigning payment to billing NPI/TIN ____other	
☐	Check if provider is eligible type:___Physcian (MD,DO) pediatrician, __ Nurse Practitioner, ___Certified Nurse Midwife, ___Dentist,___ Physician assistant who furnishes services in a FQHC or RHC led by a physician assistant	
☐	Check applicant and payee NPI and TIN in portal MATCH in MMIS. Check if EFT information is available in MMIS If no match or no record, then pass on to enrollment/direct to NLR http://www.cms.gov/EHRIncentivePrograms/	
	ELIGIBILITY	
☐	Check licensure information and effective dates ___license current http://doh.sd.gov/boards/ ___OIG exclusion list/list of excluded individuals/program integrity, MMIS provider file Excep 1 status http://exclusions.oig.hhs.gov	
☐	If provider practices in FQHC/RHC/Tribal , check the FQHC/RHC/Tribal clinic	
☐	If provider practices in FQHC/RHC/Tribal , check practices predominantly: FQHC/RHC is the clinical location for over 50% of total encounters over a period of 6 months in the most recent calendar year for provider- THIS IS A LOW RISK AND AUDITED POST-PAYMENT	
☐	If provider practices in FQHC/RHC/Tribal and if PA, check the *so led criteria*/documentation ___PA is a primary provider ___PA is the clinical/medical director of the FQHC/RHC ___PA is an owner of the RHC	
☐	Non hospital based unless practicing in FQHC/RHC: 90% or more of services provided under POS 21 or 23	
☐	Verify reporting date and year for patient volume is in the previous calendar year (between Jan 1-Dec 31)	
☐	If attestation is for group: ___Check clinic NPI if attesting for the group and ___verify EP practices within the group; ____verify all EPs in the group are using the same methodology for patient volume	
☐	If using patient panel method, check if EP is in Primary care case management	

☐	Using the 90 day reporting period the provider submitted to meet the 30% patient volume (20% for pediatricians), pull a claims/encounter report. Compare the claims report to the submitted/attested Medicaid patient (numerator). If there is not a close match or a large variance exists, then request for further information from provider. If a provider includes patient volume from another state, then request Medicaid claims/encounters from the state with Provider NPI; Beginning date of reporting period; Ending date of reporting period; State contacts at the Medicaid HITECH TA website Verify if using group proxy or individual; FQHC/RHC/Tribal based for individuals with needs Work with CHAD for practice predominantly	
☐	Verify clinic locations and indications for at least 50% of encounters in a setting with EHR	
	EHR STATUS	
☐	Verification of the submitted CMS EHR Certification Number available at http://onc-chpl.force.com/ehrcert Check product list, ambulatory , certification status and certification number , product name	
☐	Have documentation to adopt, implement, upgrade to a certified Electronic Health Record. Verification documents include a signed contract, user agreement, purchase order, receipt, or license agreement. A formal vendor letter should be accompanied by other forms of documentation showing financial or legal contractual commitment.	
☐	If the provider is working with HealthPOINT, then work with HealthPOINT and use HealthPOINTs resources as a secondary source of verification	
☐	For years 2-6, at least one MU public health measure met: submitted ☐ electronic data to immunization registry or ☐ electronic data to syndromic surveillance	
☐	Exclusion explanation and documentation provided and no inconsistency with reported measures for years 2-6/MU	
	ATTESTATION	
☐	Ensure all attestation information is completed, provider initialed, checked attestation terms and signed	
	ELIGIBILITY	
	☐ Eligible ☐ Not Eligible Approver Initials:_____	
	PAYMENT	
☐	If first year payment, check no previous year payment and no duplicate payments exists for provider that is using certified EHR/demonstrating AIU - 1st year; must start by 2016	
☐	Payments for a maximum of six years, no duplication payments	
☐	___ non-pediatrician with at least 30% patient volume: ___first year payment=$21,250 ___2nd-6th year payment=$8,500 ___ payment year ___ pediatrician with 20-29% patient volume: ___first year payment=$14,167 ___2nd-6th year payment=$$5,667 ___ payment year	
☐	No provider begins receiving payments after 2016 and payments end by 2021	
☐	Check for duplicate payment request. If duplicate payment request is successful, then approve for payment.	
☐	If duplicate payment request fails, notify provider	
☐	Approve for payment; notify through portal, once payment is locked, portal sends payment requests to MMIS. Note: payment must be	

	made within 4-6 weeks after verification. Payments and remits sent to provider. Update amount of payment on portal. Note timing	
☐	Track incentive payments and codes	

Appendix B. Eligible Hospital Pre-payment Verification Worksheet

Hospital Name: **Provider #:** **NPI:** **CCN:**

Program Qualification Year: **Payment Year:**

Status:

	PROCEDURE	DATE and NOTES
	REGISTRATION INFORMATION	
☐	Check if provider is enrolled in MMIS/SD Medx. If not enrolled, contact provider to direct them on how to become a South Dakota Medicaid Provider. Direct to check for active status by logging into SD MEDX at https://dss.sd.gov/sdmedx/login/login.aspx and become a Medicaid provider by enrolling with the South Dakota Division of Medical Services at 1-866-718-0084 or https://dss.sd.gov/sdmedx/includes/providers/becomeprovider/index.aspx ___not enrolled, ___enrolled as a billing provider ___enrolled as servicing provider:	
☐	Verify eligible type with the CMS Certification Number ending in _____0001 – 0879, _____1300-1399 ACH/CAH _____3300-3399 Children's and ACH ALOS of <=25 days	
☐	Check applicant and payee NPI and TIN in portal MATCH in MMIS. If no match or no record, then pass on to enrollment/direct to NLR ___EFT information present in MMIS	
☐	In good standing ___OIG exclusion list/list of excluded entities/program integrity ___currently on prepayment review, the Provider File on MMIS indicator EXCP (Exception)=1	
	ELIGIBILITY	
☐	Verify reporting date and year for patient volume is in the previous fiscal year (between Oct 1-Sept 30)	
☐	Using the 90 day reporting period the provider submitted to meet the 10% Medicaid patient volume except for CCHC or other children's hospital, pull a claims/encounter report. Compare the claims report to the submitted/attested Medicaid patient (numerator). If there is not a close match or a large variance exists, then request for further information from provider. If a provider includes patient volume from another state, then request Medicaid claims/encounters from the state with Provider NPI; Beginning date of reporting period; Ending date of reporting period; State contacts at the Medicaid HITECH TA website Patient volume is calculated using the total Medicaid patient encounters in any representative continuous 90 day period in the numerator and the total patient encounters in that same 90 day period in the preceding fiscal year. • Hospital encounters for calculating patient volume include services rendered to an individual where Medicaid paid for part or all of the inpatient discharges and emergency department services • The emergency department must be part of the hospital under the qualifying CMS Certification Number • Children's Health Insurance Program recipients must not be included Total Medicaid inpatient discharges + emergency department encounters in any representative continuous 90 day period in the preceding fiscal year	

	_____ Total patient inpatient discharges + emergency department encounters in that same 90 day period	
☐	Verify date of the base reporting year and timing	
☐	Verify total discharges, hospital charges, charity care charges, Medicaid and hospital inpatients day's data of the Medicaid cost report and compare with the pre-calculated sheet. Data may be from the CMS Form 2552-90 or 2552-10 revised cost reports for 2011 or 2012. Use new CMS Form 2552-10 as soon as available. If data is not available, request auditable data from the hospital. If using 2552-90, ask for charity care data auditable documentation to be submitted by the hospital. An "auditors report" for charity care data for CAH an option? • Ensure observation days such as nursery, psych and rehab days are excluded. Nursery bed days may not be included in the numerator or denominator for acute inpatient /hospital bed days. Note: in cases of observation days provided at a higher acute care level, then they can be included. In addition, DSH hospitals may use the DSH numbers by taking out the unpaid days • Determine if Medicaid only or dual eligible hospital. For dual-eligible hospitals, acute inpatient bed days in the numerator for patients where Medicare Part A or Medicare Advantage under Part C was the primary payer may not be included • Verify meaningful use measures for eligible hospitals attesting after January 1, 2013. Request for EHR outputs, ancillary, financial and accounting records as needed. • Use C5 and D17 • Exception: new/merged/split hospital with < 4 year data, handle as an exception. Options are to wait, or to move forward with another data source. Communicate with hospital the process and that payments may be lower than anticipated. Reconcile payment amounts.	
☐	Accurate calculation of payments, calculate and verify. Year 1 payment at 40%, year 2 at 40%, year 3 at 20% of aggregate EHR amount; Year 2 and 3 payments reconcile if necessary	
	EHR STATUS	
☐	Verify the submitted CMS EHR Certification Number available at http://onc-chpl.force.com/ehrcert	
☐	Have documentation to adopt, implement, upgrade to a certified Electronic Health Record. Verification documents include a signed contract, user agreement, purchase order, receipt, or license agreement. A formal vendor letter should be accompanied by other forms of documentation showing financial or legal contractual commitment.	
☐	If attesting for MU, at least one MU public health measure met: submitted ☐ electronic data to immunization registry or ☐ electronic data to syndromic surveillance ☐ electronic lab reporting	
☐	Exclusion explanation and documentation provided and no inconsistency with reported measures for MU	
☐	Verify with HealthPOINT if the provider is working. Check the weekly/monthly report of HealthPOINT members or request per case basis. If the provider is a HealthPOINT member, then work with HealthPOINT and use HealthPOINTs resources as a secondary source of verification	
	ATTESTATION	
☐	Ensure all attestation information is completed, provider initialed, checked attestation terms and signed	
	ELIGIBILITY	
	☐ Eligible ☐ Not Eligible Approver Initials:_____	
	PAYMENT	
☐	If first year payment, no previous year payment and no duplicates for provider that is using certified EHR/demonstrating AIU	
☐	Payments for a maximum of three years. If first year payment, verify amount of payment; If subsequent years payment, verify amount and	

	count must start by 2016 and consecutive from 2016-2021	
☐	No provider begins receiving payments after 2016 and payments end by 2021, participation for payments after 2016 is consecutive	
☐	Check for duplicate payment request. If duplicate payment request is successful, then approve for payment else notify provider	
☐	Approve for payment; notify through portal, once payment is locked, portal sends payment requests to MMIS. Note: payment must be made within 4-6 weeks after verification. Payments and remits sent to provider. Update amount of payment on portal. Note timing	
☐	Track incentive payments and codes	

Appendix C. Audit Pool for Post-payment Audit and Status Tracking

Identification						Post-Payment Audit Results					Monitoring		
Provider Name	Provider Type	NPI	TIN	Program Qualification Year	Program Year	Incentive Payment Date	Risk Rating	Selected for Audit	Audit Date	Post-Payment Audit Results	Observations/ Follow-up	Follow-Up Date	Follow-Up Status

Appendix D. Eligible Professional Post-payment Verification Worksheet

Provider Name: **Provider #:** **NPI:**

Program Qualification Year: **Payment Year:**

Status:

	PROCEDURE	DATE and NOTES
	REGISTRATION INFORMATION	
☐	If provider practices in FQHC/RHC/Tribal , check practices predominantly: FQHC/RHC is the clinical location for over 50% of total encounters over a period of 6 months in the most recent calendar year for provider- THIS IS A LOW RISK AND AUDITED POST-PAYMENT ONLY IF OTHER ISSUES RAISED	
☐	Check denominator for patient volume if not verified during pre-payment	
☐	At least 80% of patients must have data in the certified EHR	
☐	MU Core and Menu Measures are met – primary targets are those indicated as high risk • Core 5: Maintain active medication list - high • Core 6: Maintain active medication allergy list- high • Core 7: Record demographics - high • Core 13: Clinical Summaries – high • Menu 5: Patient electronic access - medium • Menu 6: Patient-specific education sources- medium • Core 1: CPOE for Medication Orders- medium • Core 3: Medication Problem List- medium • Core 4 Generate and transmit permissible prescriptions electronically (eRX)- medium • Core 8 Record Vital Signs- medium • Core 9 Record Smoking Status- medium • Menu 2: Clinical lab tests/results • Menu 4 Patient Reminders- medium • Menu 5 Patient Electronic Access – medium • Menu 6: Patient Specific Education Resources- medium • Menu 7 Medication Reconciliation- medium • Menu 8 Transition of Care Summary- medium • Core 12 Electronic Copy of Health Information- weak Sources: EHR reports, HIE, HealthPOINT, DOH, Practice management reports, Surescripts and other auditable data sources	
	☐ Appropriate Payment ☐ Inappropriate Payment	